Zarafshon Partnerships
For Scaling-Up Innovative Approaches for Rural Tajikistan
To Building Community and Health Facility Capacity
To Sustain Key Investments in Essential Maternal and Child Health Services

Cost Extension of
Cooperative Agreement No.: FAO-A-00-98-00022-00
September 30, 2002 – September 30, 2007, in
Panjikent and Aini Districts of Sugdh Region

CS-18 Tajikistan
First Year Annual Report

Prepared and Edited by:
Yousaf Hayat, Health Program Manager, SC, Tajikistan
Michael McGrath, Field Office Director, SC, Tajikistan
Eric Starbuck, Child Survival Specialist, SC, Westport

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ACRONYMS AND TERMS

ACNM	American College of Nurse-Midwives
A/N	Antenatal
ANC	Antenatal Care
APO	Assistant Project Officer
ARC	American Red Cross
ARI	Acute Respiratory Infections
BCC	Behavior Change Communication
BF	Breastfeeding
CDD	Control of Diarrheal Diseases
CDQ	Community Defined Quality
CS	Child Survival
CS-14	"Panjikent Partners," the previous CS project in Tajikistan, which ended in September 2002, of which CS-18 is a cost extension.
CS-18	The cost extension of CS-14, funded in large part through the 18th cycle of the PVO CSH Grants Program, which began in October 2002, is referred to as "CS-18" throughout this document to distinguish it from the previous "CS-14" grant, and for the sake of brevity.
CSTS	Child Survival Technical Support
CTC	Child-to-Child (health education)
DD	Diarrheal Disease
DHO	District Health Office (of the MoH)
DIP	Detailed Implementation Plan
DPT	Diphtheria-Pertussis-Tetanus immunization
EPI	Expanded Program on Immunization (MoH program and/or CS-14/-18 intervention supporting MoH immunization activities)
FAP	MoH Health Post (with no beds, staffed with a nurse, midwife, and/or feldsher)
feldsher	MoH Health technicians with approximately four years of medical training
FFW	Food-for-Work
FGD	Focus Group Discussions
FOD	Field Office Director

FY	Fiscal Year
GM	Growth Monitoring
GOT	Government of Tajikistan
HE	Health Education
HF	Health Facility
HFF	Health Facility Farm
HH	Household
HIS	Health Information System
HM	Health Monitor
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
jamoat	Collective Farm
JST	Joint Supervisory Team
KPC	Knowledge, Practices, and Coverage (survey)
LSS	Life-Saving Skills (for maternal and newborn care)
MCH	Maternal and Child Health
MIL	Mothers-in-Law
MIS	Management Information System
MNC	Maternal and Newborn Care (CS-18 intervention)
MoH	Ministry of Health
OCA	Organizational Capacity Assessment
OH	Office of Health of Save the Children
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PD	Positive Deviance
PD/H	Positive Deviance/Hearth
PDI	Positive Deviance Inquiry
PID	Pelvic Inflammatory Disease
PLG	Program Learning Group (of SC's Office of Health)

PO	Project Officer
PVO	Private Voluntary Organization
RDF	Revolving Drug Fund
RH	Reproductive Health
SC	Save the Children Federation/USA
SHM	Senior Health Monitor
SMT	Senior Management Team
SUB	MoH Rural Hospital (with 40 to 80 beds, staffed with pediatricians, gynecologists, and other specialists)
SVA	MoH Health Center (with no beds, staffed by one physician, nurses and/or midwives, and one or two feldshers)
TA	Technical Assistance
TFO	Tajikistan Field Office of Save the Children/US
TOT	Training-of-Trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee (called Village Health Committee in CS-14)
VHC	Village Health Committee (called Village Development Committee in CS-18)
VP	Village Pharmacy
WFP	World Food Program
WHO	World Health Organization
WRA	Women of Reproductive Age

A. ACCOMPLISHMENTS OF THE PROGRAM.

The most significant change that occurred in the first year of Child Survival 18 at Penjikent, Tajikistan was the geographical extension of CS impact area. Sixteen villages of Panjikent District that have difficult access to health services were included. Thirteen villages of Aini were also included as targeted villages. During the current reporting period, a total of 103 villages in Panjikent were covered by the project. In the 29 newly selected villages, Village Development Committees were elected following the previously used guidelines. Following the election and training of the VDCs, Village Pharmacists were selected. The VPs were trained and issued medicines for the establishment of Revolving Drug Funds. One of the major accomplishments of the program is an increase in the availability of and access to essential medicines in almost all villages of Panjikent.

During the reporting period, a sub-office at Aini was established and staff hired. The staff consists of an Assistant Project Officer and two health monitors. The activities started at Aini in one of the jamoats and later on extended to another jamoat.

During the fiscal year CS staff assisted the newly recruited (Mission-funded) MCH/RH project staff in conducting the baseline survey at Khatlon. CS staff provided all technical material (translated questionnaires) and training to Khatlon MCH/RH project staff. The staff acted as supervisors and trained the MCH/RH staff in questioning techniques and filling of the questionnaires; and data entry was done by CS staff.

During the fiscal year, CS-18 project started to develop a birth planning strategy. The first step was to train Child Survival staff and also MCH/RH technical staff from Khatlon. Birth Planning is very closely linked with LSS trained midwives who are involved in A/N checkups, deliveries or referral and postnatal checkup. The involvement of VDC members in establishing community alarm and transportation systems plays a crucial role in birth planning. After the completion of TOT on Birth Planning for the project staff, a series of orientation training for MoH staff working in SUBs, SVAs, and FAPs was conducted.

During this year, the project introduced the Hearth Model using the Positive Deviance Approach as a pilot in one village in Panjikent. VDC members, MoH staff and SC staff were briefed about the concept and approach, after which they conducted group discussions with community members. During the discussions existing knowledge, practices, and attitudes related to selected aspects of maternal and/or child health were clarified, in order to identify families with significant Positive Deviance (PD) behaviors. Growth Monitoring sessions were conducted in five villages, using the mother-based growth monitoring cards. This was followed by in-depth PD inquiries (PDIs) to identify and document positive behaviors among these family members. The compilation of the results has not yet been completed. Once the results are available, they will be shared with community members in feedback sessions.

Immunization mother-based card system was introduced to 16 newly selected villages at Panjikent. Monitoring visits by the health monitors continued throughout the year. Almost 3000 mothers in the villages within the CS target area are now using mother-based cards.

During fiscal year 2003, SC added 12 new Health Facility Farms to the 24 health facility farms that have reached either the second or the third cycle of project support. Two HFFs have completed all three supported crop cycles and are generating income without SC's support.

During fiscal year 2003, one LSS trainer from the CS project was used as supervisor/trainer for LSS training at Khatlon. The training is being conducted by LSS trainers/consultants for MoH midwives and gynecologists of three rayon district hospitals of Khatlon. Two gynecologist/ midwives from Aini were sent to Kurgan Tubbe for LSS training.

During this year, MoH LSS trainers at Panjikent conducted LSS training for 46 health facility staff. A total of 65 midwives at Panjikent were trained during this year. Ninety (90) midwives trained previously by these trainers received monitoring visits by these trainers. One hundred fifty-five (155) midwives assist deliveries conducted either at the health facility or at homes. The postpartum mothers and their new-borns receive care by the LSS trained midwives during their home visits.

CTC education activities have been successfully extended to 16 schools in the newly selected villages in Panjikent. One hundred forty-six (146) students of higher grades, including 87 girls and 59 boys, were trained as CTC promoters. Nine hundred and seven (907) CTC promoters of different schools received monitoring. These students disseminate health education messages to their family members throughout their respective villages.

CS-18 invited MCH/RH project technical staff to be trained on birth planning. Six technical staff from all three zonal offices attended the training.

CS-18 conducted a three-day training on Community Mobilization. The SC community mobilization manual was divided into three modules according to the Community Mobilization Cycle. Three MCH/RH Zonal Coordinators, six SC technical staff of MCH/RH project from Khatlon, the Program Manager of American Red Cross from HOPE Uzbekistan, the ARC MCH/RH Tajikistan Oblast Coordinator and the ARC MCH/RH Tajikistan zonal Coordinators attended the training. This training will be replicated for the MCH/RH project in Uzbekistan.

CS-18 arranged Revolving Drug Fund training for the newly selected pharmacists of MCH/RH project at Khatlon. This training included seven days theoretical training together with seven days practical field training.

ARC Program Manager for Community Mobilization at Uzbekistan visited Panjikent to share Village Development Committee experience. Her visit lasted for three days, during which she visited the field and had first hand interaction with the VDC members.

Factors that contributed towards accomplishments are:

a- Trained and dedicated SC staff
b- A strong working relationship with the Govt. and MoH
c- A strong relationship with the VDCs and the communities
d- Material assistance through Food Commodity Programs (HH kitchen gardens, Health Facility Farms, school/pre-school feeding program).

PROGRESS TOWARDS OBJECTIVES CHART

R-1: Improved health **practices** at household level, & increased **use** of key MCH services, in rural Panjikent and Aini districts.

Indicator 1. % of mothers who report having made 3+ ANC visits to a health facility while pregnant with youngest child.
Indicator 2. % of 0-23 month olds whose birth was attended by skilled health personnel.
Indicator 3. % of 0–5 month olds exclusively breastfed during the last 24 hours
Indicator 4. % of 12-23 month olds who received a measles vaccine (by maternal history).
Indicator 5. % of 12-23 month olds with cards, fully immunized (Measles vaccine is now given from age 12 months.)
Indicator 6. % of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.
Indicator 7. % of mothers who report hand washing before food prep. & child feeding, & after defecation & child defecation.
Indicator 8. % of households with children <2 which have only iodized salt for cooking.

Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
Household			
Pregnant women make birth plans involving their husbands and other family members.	100 pregnant women will have birth plans	No	Training on birth planning was conducted at the end of July. August and September was utilized for orientation to HF staff
Mothers have and use immunization mother based cards for their children	3000 mothers will have cards	Yes	
Postpartum mothers receive checkups by HF staff during home visits	600 post-partum mothers	Yes	
Newborns receive care from MoH health facility staff within first 8 hours of their birth.	600 newborn receive care within 1st eight hours	Yes	
Home deliveries attended by LSS trained birth attendant (MoH rural health facility staff)	600 home deliveries	Yes	
Children attending CTC sessions disseminate key health messages to their mothers, fathers and other family members.	800 children	Yes	
Mothers have and use Road to Good Health cards for their children <5	200 mothers	Yes	
Husbands & MIL of antenatal women visit HFs at least once along with the A/N woman during her pregnancy	100	No	Birth Planning activities initiated late September-Ongoing currently

Community			
VDCs arrange health education sessions for WRA and men.	90 VDCs arrange HE sessions	No	TOT for HF staff not yet conducted. In order for the MoH to conduct HE sessions, they first need to receive training on teaching methodologies and the particular topic as per the lesson plans. The VDC could not arrange these sessions because the MoH was not ready to conduct these sessions.
MoH rural HF staff, with the assistance from VDCs, conducts BCC activities with WRA.	3000 WRA reached by BCC activities	No	HF staff not trained on teaching methodologies. SC expects to conduct the TOT in December 2003.
VDCs mobilize communities for birth planning	10 VDCs	No	Birth Planning initiated in the end of September
VDCs facilitate development of emergency transport plans by pregnant women, their husbands, and other family members.	10 VDCs	Yes	On personal basis, as birth plans have not been introduced
VDCs collect and make available emergency transport funds	1 VDC will have transportation fund	No	Birth Plans not introduced
Iodized salt made available in the villages by mobilizing business persons through VDCs	75 villages	Yes	
VDCs facilitate immunization sessions by gathering all children <2 for vaccination	80 villages	Yes	
VDCs make emergency transport plans	10 VDCs	No	VDCs do assist the families in transportation, but not according to the birth planning protocols
VDCs maintain emergency transport funds	1 VDC	No	
VDCs support community-based growth monitoring sessions	5 VDCs	Yes	
VDCs organize Hearths in their villages	2 VDCs	No	PDI conducted in 5 villages involving 5 VDCs
CTC health education for children conducted at schools	80 schools	Yes	

Home work assignments for CTC trained students to review and report back on immunization cards of their younger siblings	800 students	Yes	
Health Facility			
MoH rural HF staff conduct BCC activities with WRA attending HFs.	10 HFs	No	TOT for MoH HF staff was not conducted and are expected to be carried out in December 2003 by SC staff.
HF staff conduct ANC & postpartum checkups	600 post-partum mothers	Yes	
HFs conduct at least one immunization session per month	80 HFs	Yes	
Pregnant women counseled on birth planning	100 pregnant women	No	HF staff not trained on counseling techniques. SC plans to conduct this training in the first quarter of 2004.
MoH rural HF staff counsel mothers on nutrition	5 HFs	No	HF staff not trained on counseling techniques. SC plans to conduct this training in the first quarter of 2004.
MoH rural HF staff check immunization cards during visits of children & refer children for immunization	90 HFs	Yes	
MoH rural HFs conduct planned immunization sessions	90 HFs	Yes	
MoH rural HFs use facility-based immunization registers/log books	90 HFs	Yes	
MoH rural HF staff conduct one growth monitoring session per month	5 HFs	Yes	
MoH rural HFs use facility based growth monitoring registers/log books	5 HFs	Yes	
MoH rural HF staff maintain stocks of iron supplements from VPs for distribution to the antenatal mothers	90 HFs	Yes	
Exit interviews with pregnant women & mothers of <5s to assess & improve quality of counseling	30 exit interview	No	HF staff not trained on counseling techniques

R-2: Sustained investments in key MCH services by communities & rural health facilities in Panjikent and Aini districts.

Indicator 9. % of Health Facility Farms started before 10/04, producing crops without SC support.
Indicator 10. % of all rural health facilities, which have used HFF earnings to renovate, equip, or supply the facility, or support MCH services.
Indicator 11. % of Village Pharmacies with no stock out of any antibiotic or ferrous sulfate in past month.
Indicator 12. % of Village Pharmacies with at least 65% cost recovery.

Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
Community			
VDCs assist HF staff in the formation of FFW brigades	30 VDCs	Yes	
VDCs provide technical assistance (in agriculture) to HF staff	30 VDCs	Yes	
VDCs and HF staff renovate, equip, or supply facilities, or support MCH services, using revenues collected from selling harvested crops	30 VDCs	Yes	
VDCs monitor village pharmacies.	90 VDCs monitor 90 VPs	Yes	
VDCs ensure amount owed by patients is recovered in time by VPs	90 VDCs	Yes	
VDCs ensure seed stocks in villages for HFFs	30 VDCs	Yes	
Villages establish VPs	90 Villages	Yes	
Health Facility			
HFs with farms make plans to utilize revenues and ensure supply of seeds for the next harvest	30 HFs	Yes	
HF staff participate in FFW brigade selection	30 HF staff	Yes	
HF staff monitor and supervise HFF brigades	30 HFs	Yes	
MoH rural HF staff monitor and supervise village pharmacies	90 VPs	Yes	
District			
Main pharmacy updates stock records	1	Yes	
Main pharmacy distributes medicines at least once per month	1	Yes	
Funds collected from village pharmacies once every two months	90 VPs	Yes	
RDF committee ensures replenishment of medicines when main pharmacy stocks reach 30% balance	1	Yes	
Main Pharmacy maintains all procurement records	1	Yes	
Funds recovered deposited in local bank every month	0	N/A	
Quarterly coordination meetings conducted between MoH officials and RDF committee members	2 meeting	No	The meeting was conducted among the rural MoH staff, rather than as a formal meeting at the district level.

IR-1: Increased household level **knowledge** of selected MCH issues.			
Indicator 13. % of mothers who know 2+ postpartum danger signs. **Indicator 14.** % of mothers who know 2+ newborn danger signs. **Indicator 15.** % of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection that should lead them to take their child to a health provider. **Indicator 16.** % of mothers citing both diarrhea with blood & diarrhea lasting more than 14 days as signs that should lead them to seek treatment or advice for their child.			
Activities	**Year 1 Benchmarks**	**Benchmark Achieved**	**Comments**
Household			
Children attending CTC sessions disseminate key health messages to their mothers, fathers and other family members.	800 children	Yes	
Community/ Health Facility			
VDCs facilitate BCC activities with WRA.	10 VDCs	Yes	
VDCs assist school children trained in CTC to disseminate key messages within their communities	80 VDCs	Yes	
BCC activities conducted with WRA to improve knowledge, care, & care seeking for postpartum danger signs	3000 WRA	No	Annual targets not achieved, however this process is ongoing as LSS trainers (MoH) are conducting the HE sessions for the WRA. To date, they have conducted sessions for 1,250 WRA.
BCC activities conducted with WRA to improve knowledge, care, & care seeking for newborns	3000 WRA	No	Annual targets not achieved, however this process is ongoing as LSS trainers (MoH) are conducting the HE sessions for the WRA. To date, they have conducted sessions for 1,250 WRA.
BCC activities conducted with WRA to improve knowledge, care, & care seeking for pneumonia	3000 WRA	No	1. CTC activity ongoing. 2. PD mothers have not been identified. 3. TOT on teaching methodologies not conducted, but they were given lesson plans on ARI to conduct HE sessions.

BCC activities conducted with WRA to improve knowledge, care, & care seeking for diarrhea	3000 WRA	No	1. CTC activity ongoing. 2. PD mothers have not been identified. 3. TOT on teaching methodologies not conducted, but they were given lesson plans on ARI to conduct HE sessions.
Husbands & MIL of antenatal women participate in HE sessions on A/N care & birth planning	100	No	Birth Planning orientation ongoing
VDCs and MoH have regular monthly coordination meetings	90 VDCs & MoH	Yes	
Schools in each community conduct CTC health education sessions	80 schools	Yes	
Active counseling of pregnant women on birth planning	100 women	No	Birth Planning orientation ongoing

IR-2: Improved **capacity of communities** to address priority health needs of mothers & children <5.

Indicator 17. % of villages with resident rural health facility staff, having a Village Pharmacy that sold medicines in past month.

Indicator 18. % of villages with a health facility, having a Village Development Committee which organized 1+ health education session in past month, or had a VDC meeting addressing 1+ health topic in past 2 months.

Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
Community			
VDCs established in new CS-18 villages	30 VDCs	Yes	
VDCs trained in community mobilization methods	30 VDCs	Yes	
VDCs monitor village pharmacies	90 VDCs	Yes	
VDCs assist VPs in cost recovery of funds owed by households	90 VDCs	Yes	
VDCs have regular monthly coordination meetings in villages	90 VDCs	Yes	
VDCs cross visits between old & new CS-18 sites	2 VDCs	No	Establishing VDCs in new villages completed in the middle of September. Orientation of their roles and functions are ongoing
VPs cross visits between old and new CS-18 sites for practical training on RDF activities	0	No	Completed the selection of new VPs by the end of September
VPs supplied with appropriate antibiotics and ORS	90 VPs	Yes	
Health Facility			
MoH rural HF staff support village pharmacies	90 VPs	Yes	
MoH rural HF staff participate in VDC monthly coordination meetings	90 HFs	Yes	

District			
Main pharmacy maintains stocks of appropriate antibiotics and ORS	1	Yes	
RDF committee replenishes main pharmacy when stocks reach 30%	1	Yes	

IR-3: Improved **capacity of rural health facilities** in Panjikent & Aini districts to provide quality MCH services & support community health activities.

Indicator 19. % of children <5 with diarrhea for whom all six diarrhea assessment tasks are completed by the health worker.

Indicator 20. % of children <5 with ARI for whom all four ARI assessment tasks are completed by the health worker.

Indicator 21. % of children <5 who have their weight plotted on growth chart.

Indicator 22. % of children's caretakers counseled on importance of continued breastfeeding or feeding food at home.

Indicator 23. % of ANC clinic attendees who report having received iron supplements.

Indicator 24. % of LSS-trained midwives who correctly manage normal pregnancies, deliveries, & obstetric complications.

Indicator 25. % of rural health facilities that have staff trained in LSS.

Indicator 26. % of VDC meetings that have MoH staff participating.

Indicator 27. % of villages with health facilities, with 1+ group health education sessions conducted by HF staff in last 2 months.

Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
Health Facility			
HF staff trained on WHO/ UNICEF ARI case management protocols	75HFs	Yes	
HF staff trained on WHO/ UNICEF Diarrhea case management protocols	75 HFs	Yes	
MoH staff trained in counseling techniques	90 MoH staff	No	SC expects to conduct this training in the first quarter of 2004.
MoH staff trained in Rational Drug Use	0	Yes	
MoH district officials conduct bimonthly supervisory visits to rural HFs	90 rural HFs will receive supervisory visits	Yes	
HFs equipped with basic essential instruments	75 HFs	Yes	
MoH provides vaccines and supplies to rural health facilities at least once per month.	80 HFs	Yes	
VP staff bring RDF drugs to HFs	90 HFs	Yes	
MoH rural HF staff receives regular bimonthly LSS monitoring visits.	50 HF staff	Yes	
MoH staff given on-the-spot LSS training during monitoring & supervision	40 midwives	Yes	
MoH rural HF staff given feedback reports on antenatal, delivery or postpartum referrals	50 HF staff	Yes	
MoH rural HFs provided with IEC materials	90 HFs	Yes	

District			
TOTs on teaching methodologies conducted with MoH district and rural health facility staff	90 MoH staff	No	SC expects to conduct this TOT in December 2003.
TOTs on ARI and CDD conducted with MoH district and rural health facility staff	90 MoH staff	75 MoH staff trained	Refresher provided to 75 HF staff and TOT for new staff is ongoing
TOTs on Nutrition/Growth monitoring and management of childhood malnutrition conducted with MoH district and rural health facility staff	90 MoH staff	No	We trained 5 HF staff and need to evaluate the PDI results to find out the positive behaviors and establish hearths before expanding this activity. Currently, we are only planning to expand GM activities and train MoH on GM.
MoH district and rural health facility staff trained in LSS	99 MoH staff	Yes	
Monthly reports submitted by rural HFs consolidated	90 HFs	Yes	
MoH Staff cross visits between old and new CS-18 sites	5 MoH staff	No	The staff was involved in establishing and training VDCs and VPs. As the old MoH is not conducting HE sessions or any other significant activities, we felt it would be better NOT to conduct these visits as they may have negatively impacted project activities.

IR-4: Improved **TFO capacity** to scale up successful MCH activities, present results, & expand TFO MCH programming in Tajik.

Indicator 28. Number of CS-18 strategies successfully scaled up in new CS-18 areas.
Indicator 29. Number of CS-18 strategies successfully scaled up by TFO beyond the CS-18 site.
Indicator 30. Results of 1+ innovative CS-18 strategy presented at SC OH Program Learning Group or other international forum.
Indicator 31. TFO expands MCH program implementation in Tajikistan beyond the CS-18 site.

Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
District			
SC establishes a sub-office in Aini	Yes	Yes	

SC staff cross visits between Khatlon and CS-18 site	5 SC staff	Yes	
Khatlon MCH/RH Program Manager hired		Yes	
Training courses conducted by CS-18 staff for Khatlon staff	2 trainings	Yes	
CS-18 staff supervise baseline survey at Khatlon	10 CS staff	Yes	
CS-18 pharmacist trains Khatlon pharmacists on RDF activities	3 Khatlon pharmacist trained	Yes	
CS-18 Program Manager participates in annual meetings of SC's OH Program Learning Group	Yes	Yes	
CS-18 midterm evaluation	NA	N/A	
Provision of technical materials for baseline assessments	Yes	Yes	
Joint writing, review, and revision of the Detailed Implementation Plan, & annual reports	Yes	Yes	
Technical backstopping through e-mail correspondence	Yes	Yes	
TA in formative research to develop BCC strategies and materials for MNC & Nutrition interventions, and for development of training materials & curricula for trainers of rural HF staff.	Conducted	No	Planned.
Program Manager participates in SC regional PD/H training, and trains TFO staff in PD/H	Conducted	Yes	PM attended the workshop two years ago and trained the staff that same year. The staff conducted PDIs in the current FY.
TA visit from ACNM to follow-up training of MoH midwives in LSS	Conducted	Yes	

B. FACTORS WHICH HAVE IMPEDED PROGRESS TOWARDS ACHIEVEMENT

The factors that impeded progress towards achievement of objectives and actions taken by the project are stated below:

1. ***Program Manager was unable to spend as much time as expected on CS-18 implementation due to his other responsibilities as Acting Program Manager for the MCH/RH project in Khatlont.***[1]
   - è This role was initially expected to be short-term. However, after both Project HOPE and USAID expressed reservations about the suitability of the national staff member proposed by SC as Program Manager of the MCH/RH Program, it was decided to convert that position to an international position. The process of seeking funding for and filling the position was time-consuming, with the result that for most of the year the CS-18 Program Manager was also effectively responsible for the management of the MCH/RH Project.
   - è The distance between the two projects is almost 500 kilometers. Travel is difficult, especially during winter when Anzob Pass is closed for six months due to heavy

[1] Please note that this refers to Dr. Yousaf Hayat, SC's Health Program Manager for Tajikistan, who has part-time responsibility for CS-18, not the CS Project Officer, Dr. Boboeva Sailigul, who continues to be involved in CS-18 on a full-time basis (as originally planned and described in the CS-18 application and budget).

snow. At this time, it is necessary to travel via Uzbekistan, which is an 8-10 hour journey.

2. ***Reduced number of staff in spite of geographical and programmatic expansion.***[2]
   - è Although the CS-18 project is working in two districts, compared to the one district covered by CS-14, and includes double the number of villages, the number of field staff available is less than was the case for CS-14.
   - è As a result, several positions have had to be combined, and staff are stretched.
   - è The project staff started activities in the new villages near to Panjikent, and later expanded in the direction of Aini.
   - è In Aini District the project has commenced in the jamoats and villages closest to Aini town.

3. ***Establishing Sub-Office at Aini. Lack of appropriate space for the office.***
   - è It was quite difficult to identify suitable premises for an office in Aini.
   - è As a result, the project acquired a room at the district hospital until an appropriate office was found.

4. ***Increase in emigration rate of health facility staff***
   - è Salaries for health facility staff are very low. As a result, it is natural that many staff consider seeking alternative sources of income. The most common such source, given the limited alternative employment opportunities in the local area or in Tajikistan in general, is seasonal or permanent migration to Russia in search of work. Such out-migration threatens to undermine the successes achieved by the project over the past years.
   - è The project has sought to address this problem by providing health workers with access to alternative sources of income in the local area. Accordingly, the project sought and received WFP commodities to support FFW for the rehabilitation of 18 health facilities. Health workers were preferentially employed on these rehabilitation activities. The materials required for the rehabilitation of the health facilities were paid for out of the proceeds from the sale of produce from the health facility farms.

5. ***Winter access to some villages was impossible due to heavy snow***
   - è The 2002-2003 winter was the coldest for ten years, with extensive snowfalls.
   - è As a result, program activities focused on the villages that had been covered in the CS-14 program, which were easier to access, until access to the new villages was possible.

6. ***CS-18 staff had to support the new MCH/RH project, particularly during the MCH/RH baseline survey.***
   - è The design for the MCH/RH project in Khatlon calls for the CS-18 project to be a mentoring site for the MCH/RH project. This obligation necessarily means that CS-18 staff have had to dedicate some of their time to the support of the new project.

[2] Please note that this is consistent with CS-18 plans as described in the application and DIP, as CS-18 was planned to involve less direct implementation by SC staff, and more by MoH staff, than was the case in CS-14.

- In particular, CS-18 staff were instrumental in the successful implementation of the MCH/RH baseline study, which took place over a month in late February and March 2003. As the MCH/RH staff had only just been hired, it would not have been possible for them to have completed the task without substantial assistance from the CS-18 project.

C. TECHNICAL ASSISTANCE

Technical assistance is required in training and involving the communities in Partnering/ Institutional Development. Training on IMCI approach and Community Defined Quality will also help the project in pilot testing the approaches in Tajikistan. Recently, the GOT has informally accepted IMCI for national implementation; however this still needs to be formally approved. We expect this to happen in November 2003. Therefore, SC will be hiring a consultant to train both MoH and SC/Tajikistan staff on CS and MCH/RH. Dr. Tariq Ihsan, SC's Asia Regional Health Adivsor will conduct the CDQ and PID workshops for the MoH and SC/Tajikistan CS and MCH/RH staff in July 2004.

D. SUBSTANTIAL CHANGES IN THE PROGRAM DESCRIPTION

There have been no substantial changes from the program description /DIP that will require a modification to the Cooperative Agreement.

E. RESPONSE TO RECOMMENDATIONS MADE IN THE DIP REVIEW

The Tajikistan CS-18 DIP was "approved with no revisions." However, our responses and actions taken in response to comments by DIP reviewers are as follows:

Responses to Nancy Keith:

Point 1-Exclusive breastfeeding for infants 0-6 months old is one of our project's indicators. She pointed out that there should be a behavior change strategy for improving BF behaviors-this is included in the BCC table.

Point 2-All suggestions will be included in the lesson plans and then determined in FGDs to the extent that they are practices through the HE sessions.

Point 3-The plan to identify PD mothers is already included.

Point 4-This will be determined in the PDI.

Other Comments-Grandmothers/MIL are included in birth planning. This issue will be discussed during counseling sessions where the husbands and MILS will attend along with the pregnant women. Other points in this section will be addressed in the lesson plans.

Complementary Feeding-All suggestions will be addressed in the lesson plans.

Feeding During Illness-This will be addressed in the lessons plans. This is also addressed individually in ARI and CDD.

Growth Monitoring and Management of Childhood Malnutrition-We are introducing GM and this will help to identify children with mild malnutrition.

Maternal Nutrition-We will not focus on calories, but this will be addressed through one of our lesson plans. The food utilized will be whatever is available or affordable locally.

Responses to Mary Ann Mercer Notes:
Establishing Aini office and having staff locate in Aini will help to reduce the problems. Expansion to Khatlon is a scaling-up of CS-18.

Responses to Leo Ryan's/CSTS Notes:
Point 1-Yes, there is an opportunity to evaluate both old and new site outcomes. This will be considered during evaluations.
Point 2-The Project focus will be that this practice continues, but the major focus will be on the quality of services provided by these birth attendants.

F. PROGRAM MANAGEMENT SYSTEM

Financial Management system.

SC will continue to provide managerial and logistical support to hire and support project staff. All financial and administrative procedures will be compatible with SC's standard operating procedures and comply with USAID regulations. To this end, the Panjikent Finance Officer and the Health Program Manager liaise with SC Field Office staff based in Dushanbe, including Finance and Operations Support staff and the Deputy FO Director (DFOD), on a regular basis to discuss current project requirements and program direction in budgeting and financing. Quarterly and annual budgets are developed in Panjikent, and submitted to the DFOD and Finance Department in Dushanbe for approval. Expenditures are recorded at the time of the expenditure. Finance reports are reviewed every month in Panjikent by the Health Program Manager and by finance staff, are submitted to SC's Dushanbe Finance Department on a monthly basis, and are incorporated into the Field Office's monthly report to SC Headquarters in Westport.

Human Resources.

SC staff based in Dushanbe

Field Office Director and Deputy Field Office Director for Admin. and Finance (2.5% each, plus SC match for the FOD only): Provide overall guidance and relations with MoH, USAID Mission, and other organizations.

Finance Manager (10%): Responsible for fiscal oversight and financial reporting in compliance with grant policies and procedures.

Admin. Manager and Admin. Assistant (10% each): Responsible for administration oversight in compliance with grant policies and procedures.

SC Health Program Manager (25%): Responsible for technical content of training and services, staff training and supervision.

SC staff based in Panjikent and Aini districts:

CS Project Officer (100%): Responsible for over-all on site management, assisting Program Manager with the overall planning and implementation of CS-18 activities, including monitoring the development of community-based providers, and ensuring productive collaboration with the DHOs and other local partners. PO is responsible for organization and implementation of training activities for all CS interventions, including materials development, and district health planning and management for SC and MoH staff. PO provides technical support for training organized by the DHOs and health education sessions conducted at the community level by the rural MoH health facility staff in Panjikent and Aini districts.

Ass. Project Officer (100%): The APO is responsible for assisting the Project Officer with the overall planning and implementation of CS-18 activities, particularly in Aini District, including monitoring the development of community-based providers, and ensuring productive collaboration with the DHOs and other local partners. The APO is responsible for facilitating the design/ improvement of training materials, and providing technical assistance and monitoring of training courses conducted by SC and MoH staff. The APO is responsible for the overall performance of the Health Monitors, health education sessions conducted by MoH rural health facility staff, joint supervisory visits with the rural hospitals staff to health centers and health posts, and assisting the rural health facility staff with the HIS at Aini. He will also provide technical support to MoH counterparts for establishing the mother-based immunization card system.

Senior Health Monitor (SHM) (100%): The role of the SHM is very similar to that of the APO, except that her work will continue to be focused in Panjikent District.

Pharmacist (100%): Coordinates all the activities related to revolving drug funds (RDFs). The Pharmacist assists the Project Officer and is the focal person for expanding RDF activities, including establishing a main pharmacy at Aini, establishing village pharmacies in new CS-18 areas, establishing an RDF bulk purchasing committee in Aini, inputs from the MoH, assisting the Project Officer in training village pharmacists and VDC members, and keeping RDF records in compliance with project policies.

Maternal and Newborn Care Monitor (LSS trainer) (100%): The MNC Monitor assists the Project Officer with MNC activities, and is the focal person for expansion of LSS training in Panjikent and Aini, mobilizing the DHO, health facility staff, and VDCs for improved maternal and newborn care. Together with SC and MoH counterparts, the MNC Monitor's responsibilities include: (1) advocacy for maternal and child health from community to district levels; (2) mobilization of women at community level for family health, focusing on maternal and newborn care; (3) inputs for training MoH personnel, VDC members, and CS-18 partners; (4) assisting with development of messages and testing innovative delivery channels (drama, song, etc.); (5) motivating and planning with MoH counterparts, and; (6) working with Maternity Department Chief Doctors.

MIS Assistant (100%): Under the supervision of the Project Officer, the MIS Assistant is responsible for the design of health information systems, data collection forms, and computer programs; training others in computing; and collection of data from the health monitors, and from pharmacy and MoH staff. The MIS Ass. is also responsible for designing questionnaires,

EPI Info programs, data entry, and analysis for surveys; performing and/or supervising accurate entry of all collected data; maintaining computers in working order; and submitting data and reports in a timely manner to the appropriate person.

7 Health Monitors (100% each): Coordinates with MoH Master Trainers to facilitate training of rural health facility staff. They are responsible for mobilizing communities in new CS-18 villages, and establishing and training VDCs. After the VDCs are established, the HMs will coordinate the activities of VDCs and MoH rural health facilities, focusing on maternal and child health issues, including referrals, birth plans, planning for emergency obstetric transportation, setting up the child registry system, etc. The HMs monitor health education sessions conducted by rural health staff, and maintain good relations with women's groups, school children who are CTC trainers, school staff, and community members. The HMs assist with rural health facility documentation and analysis of monthly reports, including those for immunization and MNC.

Finance Officer (100%): Responsible for keeping financial records and for financial reporting.

Admin. Assistant (100%): Responsible for procurement, record keeping, stores and general administration of the office.

Backstopping & Technical Assistance from SC's Headquarters & Regional Health Advisor: Regular technical and administrative assistance and monitoring of CS-18 from SC's home office include: provision of technical materials for baseline assessments; joint writing, review, and revision of the Detailed Implementation Plan, annual reports, and other technical documents; participation in mid-term and final evaluations; annual program review and technical assistance visits to the site; technical backstopping through frequent e-mail correspondence encouraging the field office to seek technical materials and guidance from the home office, and prompt responses to queries from Tajikistan; and regular internal and external auditing. Key SC Home Office staff supporting CS-18 include: Dr. Eric S. Starbuck, Child Survival Specialist, responsible for technical backstopping and guidance from Westport, Connecticut; and Ms. Carmen Weder, Office of Health Manager, based in Westport. Dr. Tariq Ihsan, SC's Regional Health Advisor for Asia, based in Islamabad, provides technical assistance and oversight, particularly with regard to planning, and baseline and other assessments.

Communication system and team development.

Much of the collection and use of data for CS-18 project management is integrated with the MoH system, since MoH staff are the only providers of health services. SC works diligently with MoH counterparts to rationalize existing information systems to capture essential information for monitoring both CS-18 objectives and MoH requirements.

At health the facility and community level, for the purpose of maintaining uniformity of reporting instruments throughout Panjikent and Aini districts, the MoH monthly reporting forms are used unaltered in Panjikent and Aini districts. MoH and SC joint supervisory teams (JSTs) provide supervisory support to VDCs and rural health facility staff on a monthly basis, reviewing data analysis and actions taken by facilities and communities. The JSTs consolidate data of rural hospitals and their catchment health facilities, calculate key indicators, identify problems, and

take action at their level, and compile a report that incorporates problems identified, actions taken, and request for assistance required from the DHO.

Local partner relationships.

Following the signing of contracts with VHC and Village Pharmacists and establishing relationships with the MoH staff, SC facilitates a meeting between a representative of the VHC, MoH and the village pharmacist. During the initial meeting each partner reviews his/her responsibilities for the others. A schedule and venue is established for regular monthly meetings. These partnership meetings provide a forum to constructively review interval successes and shortcomings, problem-solve, plan, and share information. In preparation for and during meetings, partners receive training on meeting facilitation, priority setting, problem-solving, organizational structure, team building, and partnering.

PVO coordination/collaboration in country.

SC coordinates with other PVOs within the country. Tajikistan Red Crescent health staff attended the Community Mobilization workshop conducted at Panjikent. The RDF documentation has been shared with CARE International. Coordination meeting and staff cross visits with Agha Khan Foundation has been planned.

Information management.

Process to Gather, Analyze, and Use Data in Project Management in Relation to MoH HIS

Village pharmacies: VPs are completing daily patient logs and maintaining stock books. The VPs are compiling and submitting the monthly patient disease report to the local health facility. SC's Pharmacist and the MoH Pharmacy Assistant monitor the activities and performance of the VPs by checking these records at least once a month, which include information on the previous balance, new medicines received, total disbursements, total cost recovered, and the present balance. The village pharmacy reports are crosschecked with the monthly main pharmacy report.

Health education: MoH staff will submit information to the DHO on the number of health education sessions conducted, topics covered, and number of attendees. SC staff will monitor a sample of these sessions, hold focus group discussions with samples of women on a regular basis to assess knowledge and practices related to key MCH issues, and submit reports of findings to SC.

Child-to-Child health education: The report of CTC education continues to track the number of schools that conduct CTC, the number of attendees, and the topics covered. SC Health Monitors will conduct periodic FGDs with mothers of trained children, and with the trained children themselves, to monitor knowledge and self-reported home practices related to the CTC training.

Growth monitoring and management of childhood malnutrition, ARI, and diarrhea: Health worker practices in ARI case management and ORT corners at every MoH health facility are

being monitored on a bimonthly basis by MoH and SC supervisors using a checklist. CS and MoH staff will introduce periodic exit interviews with mothers during these supervisory visits. ARI reporting by health workers is monitored regularly to ensure that all children with ARI are recorded in the patient log, indicating age of the child, respiratory rate, presence of chest indrawing, diagnosis, and treatment. MoH staff submit ARI and CDD patient/disease monthly reports and ORT corner reports, with total number of children treated by age and diagnosis, to the DHO on a monthly basis. Bimonthly growth monitoring sessions at health facilities are regularly conducted in five health facilities introducing the mother-based GM cards. During the supervisory visits conducted by Joint Supervisory Team (JST) monitor performance of health workers by supervisory checklist and review the daily and permanent registers. The health workers responsible for immunization report the total number of children immunized by antigen and dose, and track and report on the DPT dropout rate for their area. Home-based immunization cards have been introduced in all villages of Panjikent, and will be introduced within this current fiscal year in Aini. When the cards are handed over to the mothers, duplicate records in the form of immunization registers (daily and permanent) are kept at the health facility. By referring to the permanent register, the health worker is able to determine the number and names of the children due for vaccination. Immunization will be planned together with the VDCs. The list of children due for vaccination will be provided by health facilities to VDC members for referral for vaccination during the vaccination sessions. The permanent register is used to identify dropouts. After compiling the monthly report, facilities prepare a list of all defaulters and dropouts and give this to the VDCs, which will trace the defaulters for participation in the next immunization session.

MNC and child registry system: CS-18 introduced a child registry system at health facilities. VDC members are encouraged to report all births in the communities, which are recorded in the birth register and referred for immunization. SC has introduced Partogram in all the Health Facilities. The midwives are trained in the recording of Partograph. CS-18 has introduced MoH-approved ACNM LSS monitoring forms.

Organizational Capacity Assessments.

The OCA was conducted in 2001 and the report of this assessment and actions taken by the TFO will be revised/written by Lisa Krift and submitted soon.

G. WORK PLAN

The work plan for the second year is as follows.

CS-18 Work Plan for Year 2

R-1: Improved health **practices** at household level, & increased **use** of key MCH services, in rural Panjikent and Aini districts.	
Indicator 1. % of mothers who report having made 3+ ANC visits to a health facility while pregnant with youngest child.	KPC survey
Indicator 2. % of 0-23 month olds whose birth was attended by skilled health personnel.	KPC survey
Indicator 3. % of 0–5 month olds exclusively breastfed during the last 24 hours	KPC survey
Indicator 4. % of 12-23 month olds who received a measles vaccine (by maternal history).	KPC survey
Indicator 5. % of 12-23 month olds with cards, fully immunized (Measles vaccine is now given from age 12 months.)	KPC survey
Indicator 6. % of children ill with ARI or DD in past 2 weeks who received increased fluids & continued feeding during the illness.	KPC survey
Indicator 7. % of mothers who report hand washing before food prep. & child feeding, & after defecation & child defecation.	KPC survey
Indicator 8. % of households with children <2 which have only iodized salt for cooking.	KPC survey

Major Activities	**2003**			**2004**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 2**
Household														
Pregnant women make birth plans involving their husbands and other family members.	X	X	X	X	X	X	X	X	X	X	X	X	SC staff will facilitate	600 pregnant women will have birth plans
Mothers have and use immunization mother based cards for their children	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff SC will provide cards	8000 mothers will have cards
Postpartum mothers receive checkups by HF staff during home visits	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	1800 post-partum mothers
Newborns receive care from MoH health facility staff within first 8 hours of their birth.	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	1800 newborn receive care within 1st eight hours
Home deliveries attended by LSS trained birth attendant (MoH rural health facility staff)	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	1800 home deliveries
Children attending CTC sessions disseminate key health messages to their mothers, fathers and other family members.		X		X		X		X		X		X	Students assisted by VDCs & SC	1200 children
Mothers have and use Road to Good Health cards for their children <5	X	X	X	X	X	X	X	X	X	X	X	X	SC staff	400 mothers
Husbands & MIL of antenatal women visit HFs at least once along with the A/N woman during her pregnancy	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	600
Community														
VDCs arrange health education sessions for WRA and men.	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	120 VDCs arrange HE sessions

MoH rural HF staff, with the assistance from VDCs, conducts BCC activities with WRA.	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	12000 WRA reached by BCC activities
VDCs mobilize communities for birth planning		X	X	X				X	X	X			VDCs	30 VDCs
VDCs facilitate development of emergency transport plans by pregnant women, their husbands, and other family members.	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	30 VDCs
VDCs collect and make available emergency transport funds				X	X					X	X		SC will facilitate	5 VDC will have transportation fund
Iodized salt made available in the villages by mobilizing business persons through VDCs	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	120 villages
VDCs facilitate immunization sessions by gathering all children <2 for vaccination	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	120 villages
VDCs make emergency transport plans	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	30 VDCs
VDCs maintain emergency transport funds				X	X					X	X		SC will facilitate	5 VDC
VDCs support community-based growth monitoring sessions				X	X	X				X	X	X	SC will facilitate	15 VDCs
VDCs organize Hearths in their villages								X	X	X	X		SC will facilitate	6 VDCs
CTC health education for children conducted at schools	X	X	X	X	X	X	X	X	X	X	X	X	School teachers	100 schools
Home work assignments for CTC trained students to review and report back on immunization cards of their younger siblings	X	X	X	X	X	X	X	X	X	X	X	X	SC CTC promoter	1200 students
Health Facility														
MoH rural HF staff conduct BCC activities with WRA attending HFs.	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	30 HFs
HF staff conduct ANC & postpartum checkups	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	1800 post-partum mothers
HFs conduct at least one immunization session per month	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	120 HFs
Pregnant women counseled on birth planning	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	600 pregnant women
MoH rural HF staff counsel mothers on nutrition	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	
MoH rural HF staff check	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	120 HFs

immunization cards during visits of children & refer children for immunization														
MoH rural HFs conduct planned immunization sessions	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	120 HFs
MoH rural HFs use facility-based immunization registers/log books	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	120 HFs
MoH rural HF staff conduct one growth monitoring session per month				X	X	X				X	X	X	SC will facilitate	15 HFs
MoH rural HFs use facility based growth monitoring registers/log books				X	X	X				X	X	X	SC will facilitate	15 HFs
MoH rural HF staff maintain stocks of iron supplements from VPs for distribution to the antenatal mothers	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	120 HFs
Exit interviews with pregnant women & mothers of <5s to assess & improve quality of counseling				X				X				X	SC staff	50 exit interview

R-2: Sustained investments in key MCH services by communities & rural health facilities in Panjikent and Aini districts.														
Indicator 9. % of Health Facility Farms started before 10/04, producing crops without SC support. **Indicator 10.** % of all rural health facilities, which have used HFF earnings to renovate, equip, or supply the facility, or support MCH services. **Indicator 11.** % of Village Pharmacies with no stock out of any antibiotic or ferrous sulfate in past month. **Indicator 12.** % of Village Pharmacies with at least 65% cost recovery.														Final Eval. Final Eval. VP records RDF Reports
Major Activities	**2003**			**2004**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 2**
Community														
VDCs assist HF staff in the formation of FFW brigades	X	X						X	X				SC will facilitate	36 VDCs
VDCs provide technical assistance (in agriculture) to HF staff						X	X	X		X	X		VDCs	36 VDCs
VDCs and HF staff renovate, equip, or supply facilities, or support MCH services, using revenues collected from selling harvested crops	X	X							X	X			SC will facilitate	36 VDCs
VDCs monitor village pharmacies.	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	120 VDCs monitor 120 VPs
VDCs ensure amount owed by patients is recovered in time by VPs	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	120 VDCs
VDCs ensure seed stocks in villages for HFFs	X	X						X	X				VDCs	36 VDCs

Villages establish VPs	X	X					X	X					Pharmacist	120 Villages
Health Facility														
HFs with farms make plans to utilize revenues and ensure supply of seeds for the next harvest	X	X							X	X			VDCs	36 HFs
HF staff participate in FFW brigade selection	X	X						X	X				MoH staff	36 HF staff
HF staff monitor and supervise HFF brigades						X	X	X		X	X		MoH staff	36 HFs
MoH rural HF staff monitor and supervise village pharmacies								X	X				Pharmacist	120 VPs
District														
Main pharmacy updates stock records	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	2
Main pharmacy distributes medicines at least once per month	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	2
Funds collected from village pharmacies once every two months	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	120 VPs
RDF committee ensures replenishment of medicines when main pharmacy stocks reach 30% balance							X					X	SC will facilitate	2
Main Pharmacy maintains all procurement records							X					X	Pharmacist	2
Quarterly coordination meetings conducted between MoH officials and RDF committee members			X			X			X			X	Pharmacist	4 meeting
Quarterly coordination meetings conducted between MoH district officials and Agriculture district department officials						X						X	SC will facilitate	2

IR-1: Increased household level **knowledge** of selected MCH issues.	
Indicator 13. % of mothers who know 2+ postpartum danger signs.	KPC survey
Indicator 14. % of mothers who know 2+ newborn danger signs.	KPC survey
Indicator 15. % of mothers citing both rapid breathing & chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider.	KPC survey
Indicator 16. % of mothers citing both diarrhea with blood & diarrhea lasting more than 14 days as signs which should lead them to seek treatment or advice for their child.	KPC survey

Major Activities	**2003**			**2004**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 2**
Household														
Children attending CTC sessions	X	X	X	X	X	X	X	X	X	X	X	X	SC will	1200 children

disseminate key health messages to their mothers, fathers and other family members.													facilitate	
Community/Health Facility														
VDCs facilitate BCC activities with WRA.	X	X	X				X	X	X	X			VDCs	30 VDCs
VDCs assist school children trained in CTC to disseminate key messages within their communities		X		X		X		X		X		X	SC will facilitate	100 VDCs
BCC activities conducted with WRA to improve knowledge, care, & care seeking for postpartum danger signs	X	X			X	X			X	X			MoH staff	12000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for newborns	X	X			X	X			X	X			MoH staff	12000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for pneumonia	X	X	X										MoH staff	12000 WRA
BCC activities conducted with WRA to improve knowledge, care, & care seeking for diarrhea							X	X	X	X			MoH staff	12000 WRA
Husbands & MIL of antenatal women participate in HE sessions on A/N care & birth planning			X	X	X						X	X	SC will facilitate	600
VDCs and MoH have regular monthly coordination meetings	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	120 VDCs & MoH
Schools in each community conduct CTC health education sessions	X	X	X	X	X	X	X						SC will facilitate	100 schools
Active counseling of pregnant women on birth planning	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	600 women

IR-2: Improved **capacity of communities** to address priority health needs of mothers & children <5.														
Indicator 17. % of villages with resident rural health facility staff, having a Village Pharmacy that sold medicines in past month. CS-18 Records **Indicator 18.** % of villages with a health facility, having a Village Development Committee which organized 1+ health education Session in past month, or had a VDC meeting addressing 1+ health topic in past 2 months. CS-18 Records														
Major Activities	**2003**			**2004**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 2**
Community														
VDCs established in new CS-18 villages	X	X	X										SC staff	50 VDCs
VDCs trained in community mobilization methods	X	X	X	X									SC staff	50 VDCs

VDCs monitor village pharmacies	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	120 VDCs
VDCs assist VPs in cost recovery of funds owed by households	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	120 VDCs
VDCs have regular monthly coordination meetings in villages	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	120 VDCs
VDCs cross visits between old & new CS-18 sites	X	X								X	X		PO & APO	6 VDCs
VPs cross visits between old and new CS-18 sites for practical training on RDF activities	X	X							X	X			PO & APO	10
VPs supplied with appropriate antibiotics and ORS	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	120 VPs
Health Facility														
MoH rural HF staff support village pharmacies								X	X				SC will facilitate	120 VPs
MoH rural HF staff participate in VDC monthly coordination meetings	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	120 HFs
District														
Main pharmacy maintains stocks of appropriate antibiotics and ORS	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	2
RDF committee replenishes main pharmacy when stocks reach 30%							X					X	SC will facilitate	1

IR-3: Improved **capacity of rural health facilities** in Panjikent & Aini districts to provide quality MCH services & support community health activities.	
Indicator 19. % of children <5 with diarrhea for whom all six diarrhea assessment tasks are completed by the health worker.	HFA
Indicator 20. % of children <5 with ARI for whom all four ARI assessment tasks are completed by the health worker.	HFA
Indicator 21. % of children <5 who have their weight plotted on growth chart.	HFA
Indicator 22. % of children's caretakers counseled on importance of continued breastfeeding or feeding food at home.	HFA
Indicator 23. % of ANC clinic attendees who report having received iron supplements.	HFA
Indicator 24. % of LSS-trained midwives who correctly manage normal pregnancies, deliveries, & obstetric complications.	ACNM LSS forms
Indicator 25. % of rural health facilities that have staff trained in LSS.	ACNM LSS forms
Indicator 26. % of VDC meetings, which have MoH, staff participating.	VDC Records
Indicator 27. % of villages with health facilities, with 1+ group health education sessions conducted by HF staff in last 2 months.	HF Records

Major Activities	**2003**			**2004**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 2**
Health Facility														
HF staff trained on WHO/ UNICEF ARI case management protocols	T	T R	T R										SC staff	120HFs
HF staff trained on WHO/ UNICEF								T	T				SC staff	120 HFs

Diarrhea case management protocols								R	R					
MoH staff trained in counseling techniques		T	T	T							R	R	SC staff	150 MoH staff
MoH staff trained in Rational Drug Use								X	X				SC staff	0
MoH district officials conduct bimonthly supervisory visits to rural HFs	X		X		X		X		X		X		MoH staff	120 rural HFs will receive supervisory visits
HFs equipped with basic essential instruments										X	X		SC staff	90 HFs
MoH provides vaccines and supplies to rural health facilities at least once per month.	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	120 HFs
VP staff bring RDF drugs to HFs	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	120 HFs
MoH rural HF staff receives regular bimonthly LSS monitoring visits.		X	X			X	X	X		X	X	X	SC MNC monitor	90 HF staff
MoH staff given on-the-spot LSS training during monitoring & supervision	X	X			X	X	X			X	X	X	SC MNC monitor	40 midwives
MoH rural HF staff given feedback reports on antenatal, delivery or postpartum referrals	X	X			X	X	X			X	X	X	SC MNC monitor	90 HF staff
MoH rural HFs provided with IEC materials	X										X		SC	120 HFs
District														
TOTs on teaching methodologies conducted with MoH district and rural health facility staff	T	T	T										SC staff	150 MoH staff
TOTs on ARI and CDD conducted with MoH district and rural health facility staff	T	T R	T R					T R	T R				SC staff	150 MoH staff
TOTs on Nutrition/ Growth monitoring and management of childhood malnutrition conducted with MoH district and rural health facility staff								R	R	T	T		SC staff	150 MoH staff
MoH district and rural health facility staff trained in LSS	T						T	T					SC staff	120 MoH staff
Monthly reports submitted by rural HFs consolidated	X	X	X	X	X	X	X	X	X	X	X	X	MoH staff	120 HFs
MoH Staff cross visits between old and new CS-18 sites		X									X		PO & APO	15 MoH staff

Main Pharmacy established at District Hospital, Aini		X											Pharmacist	1

IR-4: Improved **TFO capacity** to scale up successful MCH activities, present results, & expand TFO MCH programming in Tajik.	
Indicator 28. Number of CS-18 strategies successfully scaled up in new CS-18 areas.	Final Evaluation
Indicator 29. Number of CS-18 strategies successfully scaled up by TFO beyond the CS-18 site.	Final Evaluation
Indicator 30. Results of 1+ innovative CS-18 strategy presented at SC OH Program Learning Group or other international forum.	PLG Report
Indicator 31. TFO expands MCH program implementation in Tajikistan beyond the CS-18 site.	TFO Reports

Major Activities	**2003**			**2004**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 2**
District														
SC staff cross visits between Khatlon and CS-18 site		X									X		PM	10 SC staff
Training courses conducted by CS-18 staff for Khatlon staff									X		X		PM & PO	4 trainings
CS-18 pharmacist provides refresher course for Khatlon pharmacists on RDF activities									X	X			Pharmacist	
CS-18 Program Manager participates in annual meetings of SC's OH Program Learning Group								X					OH SMT	Yes
CS-18 midterm evaluation											X		CS Specialist	Done
Joint writing, review, and revision of the Detailed Implementation Plan, & annual reports												X	CS Specialist	Yes
Technical backstopping through e-mail correspondence	X	X	X	X	X	X	X	X	X	X	X	X	CS Specialist	Yes
TA in formative research to develop BCC strategies and materials for MNC & Nutrition interventions, and for development of training materials & curricula for trainers of rural HF staff.									X				SC Regional Health Advisor	Conducted
Program Manager participates in SC regional PD/H training, and trains TFO staff in PD/H			X										Program Manager	
TA visit from ACNM to follow-up training of MoH midwives in LSS										X			Program Manager	